GABRIELA CORÁ, MD, DFAPA, MHA, MBA
DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY
EXECUTIVE WELLNESS, INC.
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GENERAL RELEASE

I hereby authorize my physician, Gabriela Corá, MD, to diagnose and treat the condition or conditions from which I am suffering by such means including diagnostic biometrics, therapeutic intervention procedures including medication treatments, as she believes indicated by her assessment of my case.

I am aware that the practice of medicine is not an exact science, that complications may occur and that no guarantees have been made to me concerning the results of my medical treatment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Gabriela Corá, MD, to release any medical information regarding substance abuse, HIV, and psychiatric treatment to any insurer, third party payers, the Social Security Administration or any agents, attorneys and consultants it reasonably deems necessary to assist in securing payment for services, improving patient care services, or for discharge planning, risk management or performance improvement purposes. I also authorize the release of such medical information for medical treatment and follow-up. I understand that some or all of my medical information may reside in Dr. Corá's computers. This authorization is subject to written revocation at any time except for the extent that action has been taken in reliance thereon and shall in any event expire one year following the last day of care rendered.

STATEMENT OF FINANCIAL RESPONSIBILITY

In consideration of all clinical, professional and medical services to be furnished to the patients whose name appears on this form at my request, I unconditionally guarantee full payment with no limitations to time and amount.

WAIVER OF USUAL, CUSTOMARY AND REASONABLE CLAUSES

I understand that payment for services is due at the time services are rendered. Due to Dr. Corá's specialized practice, charges may be in excess of “Usual, Customary and Reasonable” insurance plan coverage I may have. In such event, I agree that I will pay the fees in full, even though the amount may be greater than what I may be entitled to receive from my insurance company as reimbursement.

I have read all the above and understand/agree to all provisions therein regarding responsibility for payment and release of information.

Patient's Name: ____________________________ Signature: ____________________ Date: ___/___/___